Delaware Statewide Transition Plan for Compliance with Home and Community-Based (HCB) Setting Rule Amendment 1

Contents

Introduction

The *Delaware Statewide Transition Plan for Compliance with Home and Community-Based Setting Rule* (the Plan) was last updated and submitted to the Centers for Medicare & Medicaid (CMS) March 30, 2016. The Plan received initial CMS approval July 14, 2016. A copy of the Plan can be viewed at: http://dhss.delaware.gov/dhss/dmma/hcbs_trans_plan.html. Please refer to the Plan for details regarding background, covered home and community based services (HCBS), and provider settings assessed by the Department of Health and Human Services (DHSS).

From this point forward, the Plan will be amended to provide updates and the current status of DHSS transition plan activities. This is the first amendment, which also addresses CMS comments received July 14, 2016. Amendment 1 is a supplement to and builds on the Plan and demonstrates the evolution of DHSS activities to demonstrate compliance with all applicable federal requirements. The Plan is a living document that will continue to be updated as activities are completed and issues are identified.

It is important to note that the Plan provides a framework for the review of all HCBS programs offered to Delaware Medicaid recipients to ensure that each program meets all applicable home and community-based (HCB) settings requirements as prescribed in the HCBS final rule. Pathways to Employment (Pathways) (http://dhss.delaware.gov/dsaapd/pathways.html) and Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) (http://www.dhss.delaware.gov/dhss/dsamh/promise.html) were initially approved in December 2014 as meeting all HCBS final rule requirements and therefore are not subject to transition plan activities. However, both programs are included in DHSS' comprehensive oversight and monitoring of all HCBS programs to ensure ongoing compliance with all applicable federal requirements.

The activities noted below are organized according to topic areas requested by CMS. Within each area, activities are presented for the Diamond State Health Plan (DSHP), administered by the Division of Medicaid & Medical Assistance (DMMA), and the Division of Developmental Disabilities Services (DDDS) waiver, administered by DDDS, consistent with organization of activities in the Plan. To the extent possible, processes are consistent across DSHP and DDDS. Where there are differences, they are also noted below.

Site-Specific Assessment Activities and Results

The description below provides updates and results of the DSHP and DDDS site-specific assessment activities outlined in the Plan. The HCB settings assessment process is not yet completed. However, at this time no HCB settings were identified as utilizing reverse integration practices. Likewise, assessment activities did not identify any individually owned private homes that are institutional in nature. Please refer to *Ongoing Monitoring* for information regarding assessment activities moving forward.

DSHP

Provider Self-Assessments, Member Survey and Desk Review

As noted in the Plan, DMMA completed comprehensive site-specific assessment of all DSHP HCB settings, consisting of provider self-assessments, member surveys and onsite reviews. All provider settings (27 in total) were required to complete the provider self-assessment for each HCBS provided and for each setting where members receive services. Group settings were included in the assessment process. The provider self-assessment was launched September 2, 2015 and closed November 30, 2015 and yielded a 100% response rate. Details on the design, methodology and results of the provider self-assessment are found in the Plan (pages 66-70).

DMMA also used a member survey to capture information for the site-specific assessments from the member perspective and to provide the first level of validation of provider responses. The member survey was launched on September 2, 2015 and closed on December 30, 2015. Additional details on the member survey can also be found in the Plan (pages 66-70).

DMMA conducted a desk review of each provider's self-assessment results and corresponding member survey feedback. Across all provider settings, DMMA collected an average of 12 member surveys for each setting. Each member survey was evaluated and cross referenced with each provider self-assessment. Key discrepancies were noted and incorporated into the onsite review tool as discussed below.

DMMA had initially planned to use the desk review process to prioritize providers for onsite look-behind reviews (see the Plan for additional detail) (pages 70-71). However, DMMA's intent to be as comprehensive as possible with each site-specific assessment lead the agency to conduct onsite look-behind reviews for all 27 provider settings. The findings of the provider onsite look-behind reviews are detailed in the following section.

Validation Activities: Onsite Review of Every HCBS Provider Setting

As described in the Plan (pages 71-72), DMMA conducted onsite reviews of provider settings between March 1, 2016 and March 17, 2016. These reviews were the second level of validation of the provider-self assessment results. An experienced team of DMMA nurses were responsible for completing the onsite reviews. The onsite review team has extensive experience conducting provider onsite reviews, which DMMA leveraged in designing the approach to the reviews.

DMMA developed a standardized onsite review tool to ensure a consistent approach to conducting the reviews. The tool included specific evaluation questions related to member choice of a non-disability setting and location of the setting relative to institutional facilities. The standardized tool included review areas that were exclusively focused on evaluating the isolation of individuals from the broader community. DMMA also included provider-specific questions for those areas where the desk review revealed discrepancies between the provider's self-assessment and the corresponding member surveys.

Details regarding the review tool and the review team's additional preparations for the onsite visits, including training, can be found in the Plan (page71).

Approximately three weeks prior to the onsite reviews, DMMA notified provider settings of the upcoming onsite review, the general timeframe of the review, and provided guidance on the process and expectations.

Onsite Review Findings and Remedial Actions

At the conclusion of the site-specific assessment process, DMMA incorporated the results of the onsite reviews with the results of the desk reviews to "bucket" provider settings into four categories:

- Category 1: Setting is compliant with federal HCB settings requirements.
- Category 2: Setting will be compliant with modifications.
- Category 3: Setting cannot meet federal HCB setting requirements and will be removed from the program.
- Category 4: Delaware will submit the setting for CMS heightened scrutiny review.

DMMA found that 14 (52%) provider settings are compliant with federal HCB settings requirements (Category 1). Twelve (44%) provider settings will require modification to achieve compliance (Category 2). No provider settings will be removed from the program and/or require relocation of members (Category 3). Delaware will submit one provider setting for CMS heightened scrutiny review (Category 4, described in *Heightened Scrutiny* below).

The following table shows the complete results of the site-specific assessment for all DSHP HCBS provider settings.

Setting Type	Compliant	Compliant w/ Modification	Removed from Program	Heightened Scrutiny
Adult Day Services	4	7	0	1
Assisted Living	9	4	0	0
Day Habilitation	1	1	0	0
Total Settings (27)	14	12	0	1

On June 2, 2016, DMMA issued a "report card" to each provider setting detailing the areas in which the provider demonstrated both compliance and non-compliance with federal HCB settings requirements. DMMA gave provider settings the opportunity to dispute the non-compliance findings and submit a request for reconsideration within 10 days from the date of the notice (details of the provider dispute process are outlined in the Plan on page 72). No provider settings disputed the results of the onsite review.

The 14 provider settings that were deemed "compliant" following the site-specific assessment process required no remedial action. These providers will be subject to ongoing monitoring activities (detailed in *Ongoing Monitoring* below).

The 12 providers that were deemed "compliant with modification" were required to submit a corrective action plan (CAP) to DMMA within 30 days of receipt of the notice. DMMA required providers to describe in their CAP the remediation activities and associated timeframes that the provider will implement to ensure compliance with each non-compliant finding. Due to the nature of certain

remediation activities, timeframes for CAP compliance varied with each setting. Provider CAPs will be closely monitored by DMMA to ensure that all elements are met as required by the CAP. To sufficiently address the CAP, providers are required to submit evidence to DMMA for each non-compliant finding noted in the report card. The evidence required by the provider varies based on the type of non-compliant finding. For example, a provider that did not demonstrate compliance with requirements protecting an individual's right to privacy was required to submit revised policies and procedures and/or evidence of the installation of additional privacy measures to demonstrate compliance. A provider noted for inadequate community integration was required to submit revised policies and procedures and describe activities the provider is implementing to improve community integration. DMMA will validate all evidence submitted for each non-compliant finding through future onsite reviews and, as appropriate, will provide technical assistance. DMMA requires that all provider settings are compliant with federal HCB settings requirements by March 17, 2019.

Key Themes

Overall the site-specific assessments demonstrated strong compliance with the HCBS federal requirements. Most settings were: compliant with integrating access and supports to the greater community, not on the grounds of a nursing facility/institution (with the exception of the one provider noted below under *Heightened Scrutiny*), promoted engagement in community life, and provided autonomy with personal resources and member choice of setting(s) including non-disability settings. Settings also have policies in place to protect the privacy of individuals, ensure person-centered service plans are comprehensive and based on member's needs, and that services and supports are inclusive of the greater community and not restrictive to just HCBS recipients. The site-specific assessments did reveal three common themes of non-compliance across provider settings that are being addressed by DMMA through the CAP process. The first theme noted for several Adult Day Services and Day Habilitation provider settings was a lack of appropriate places for members to secure belongings. A second theme noted primarily for several Adult Day Services providers, was inadequate community engagement for members, where some settings are very self-contained and did not afford members much community integration while receiving services at the setting. It should be noted however, that for many members receiving Adult Day Services, the day program itself provides more community integration to members who otherwise may just stay at home. DMMA is working with these providers to further enhance community engagement and integration for their members. A third theme noted for several Assisted Living provider settings was certain restrictive characteristics regarding privacy in member units. DMMA is currently working with these providers through the CAP process described above to remedy these issues.

DDDS

Provider Self-Assessments, Participant Survey and Desk Review

As described in the Plan (pages 33-37), DDDS mandated the completion of comprehensive site-specific provider self-assessments of all HCB settings where participants receive HCBS under the DDDS HCBS waiver. The initial phase of this process consisted of the provider-self assessments and desk reviews conducted by DDDS staff of various documents providing a status report and onsite reviews. The provider self-assessment tool was mandatory for all providers of HCBS under the DDDS waiver and all

settings. In addition to addressing all federal HCB setting requirements, the provider self-assessment required providers to indicate if the setting was on or immediately adjacent to an institution. Additional details regarding the provider self-assessment can be found in the Plan (pages 33-35).

The following table shows the complete results of the site-specific provider self-assessment for all DDDS HCBS provider settings.

Setting Type	Compliant	Compliant w/ Modification	Removed from Program	Heightened Scrutiny
Day Habilitation	6	28	1	0
Prevocational Service	5	3	0	0
Residential Habilitation*	0	429	1	0
Supported Employment	8	1	0	0
Total Settings (482)	19	461	2	0

**Neighborhood Group Home, Community Living Arrangement, Shared Living*

A total of 136 providers (including two out of state entities) completed the assessment for 482 total settings, including 94 shared living settings. The first two provider self-assessments for Day Services and Residential agency providers were launched September 4, 2015 and closed November 13, 2015. This resulted in a total of 388 provider site self-assessments. The third provider self-assessment for Shared Living Providers was launched November 11, 2015 and closed December 7, 2015. This resulted in a total of 94 self-assessments. In total, DDDS received 482 unique submissions across all services and settings, yielding an overall provider self-assessment response rate of 100%.

DDDS also implemented a participant survey for each individual receiving HCBS. DDDS indicated in the February 2016 update to the Plan (page 32) that it was not able to use the NCI data, as initially planned, as an additional data input to validate the provider self-assessments because the NCI data could not be tied to specific providers or settings. As a result, DDDS decided to develop its own participant survey, but it was not able to be launched in time to use the survey results to help target the settings selected for the onsite look-behind reviews. Instead, the surveys were used as an additional source of information to validate the provider self-assessment and onsite reviews. This altered use of the participant survey was also described in the February 2016 update to the Plan (pages 32-33).

The participant survey was launched on February 20, 2016 and was distributed to DDDS case managers and participant guardians to help encourage participant engagement with the survey. A separate survey instrument was created for recipients of residential and day services, so some members received both surveys. To protect the confidentially of participants, DDDS collects minimal identifying information in order to connect a member to a specific setting; participants are not publicly identified or shared with providers. DDDS conducted three regional trainings for case managers between February 2 and February 4, 2016 on how to assist the member to complete the survey, how to avoid influencing participant responses and submission procedures for completed surveys. Case managers and guardians have begun supporting participants in completing the survey on paper, and then mailing the survey to

DDDS. Because the waiver members and their families had recently completed the NCI survey and to avoid "over surveying" the waiver population, DDDS decided that, for members who did not have a guardian, the survey would be completed during their next annual person-centered plan review date. This means that the surveys will not be conducted for all waiver members until February 2017.

To the extent that it was available during the time the desk audits and onsite reviews were being completed, the participant survey data was used as an additional input in the validation process. At the time of this amendment, DDDS has distributed 2,074 participant surveys and received 813 completed submissions, yielding a current response rate of 39% for the participant survey. DDDS is in the process of collecting at a minimum, at least one participant survey for each HCB setting and will keep the survey open until February 20, 2017. Assuming DDDS will receive a final participant response rate similar to DMMA (85%), DDDS hopes to receive, on average, three participant surveys for each setting.

DDDS conducted desk reviews of all provider settings, between November 2015 and January 2016, as an additional validation measure. The purpose of the desk review was threefold: to ensure that each survey question was answered, to ensure that additional comments were provided where required and to validate the responses, to the extent possible, with information DDDS already had on hand. DDDS used other available data sources such as: past provider evaluations, annual Quality Service Reviews (QSR), current/past incident reports and case manager notes to validate the results of all provider self-assessments. Following submission of the March 30, 2016 iteration of the Plan, CMS requested clarification on the difference between "setting presumed not to be compliant" and "settings likely to be compliant". The language CMS questioned appeared in the original March 2015 Delaware submission of the Plan. In subsequent revisions, new "update" sections were added to the Plan to indicate both changes to the original submission and to update progress toward meeting plan milestones, but the original language was largely unchanged. In the interim, when the data became available from the provider self-assessments, it was organized into the categories enumerated on page 4 of the CMS June 2016 feedback to Delaware, instead of the categories listed in the original submission of the Plan (page 16).

The desk review revealed that 19 settings were likely compliant with federal HCB settings requirements, while 461 provider settings were presumed to be non-compliant. Of the non-compliant settings in which residential habilitation is delivered, 293 of them, including Shared Living, only need a residency agreement in place to be in compliance. Two provider settings (including one-of-out state setting) were found to be institutional in nature, one because of its location on the grounds of a public institution and the other because of the aversive practices used by the provider that they were not willing to stop using. Both settings are in the process of being removed from the DDDS waiver program. DDDS expects to complete the beneficiary relocation process for the setting on the grounds of a public institution by March 30, 2017. DDDS is in the process of transitioning the other individuals out of setting.

As noted in the systemic assessment (Attachment 6 of the Plan), DDDS decided to create a work group that will design a model residency agreement template that can be used for each of the residential setting types under the approved waiver. New model agreements will be in place for all impacted HCB provider settings no later than December 2017.

Following completion of the desk reviews, DDDS issued a "Notice of Findings" to each provider setting noting any areas of non-compliance with federal HCB settings requirements. For any findings of non-compliance, provider settings were required to submit a CAP by no later than April 1, 2016. Provider settings were also given the opportunity to dispute any of the non-compliance findings and submit a request for reconsideration within 10 days from the date of the notice. No provider settings appealed the results of the desk review and all agencies submitted CAPs within the required timeframe.

Validation Activities: Onsite Review of Minimum 20% Sample of HCBS Provider Settings

The DDDS Office of Quality Improvement (OQI) was responsible for performing validation activities under the oversight of the DDDS Advisory Council which approved the methodology for selecting the sample and the procedures for conducting the reviews at its monthly meeting of February 18, 2016. As noted in the Plan (pages 36-37), DDDS selected a 20% sample of HCBS settings to receive an onsite review. By design, the 20% sample included at least one service and setting per provider agency. Shared Living settings were not included in the onsite all agencies that were noted for non-compliance due to the residency agreement. The pool for the 20% sample included all settings that were issued a CAP during the desk review process. Within the construct indicated above, specific setting locations were selected for review if they were already scheduled for a QSR during the onsite review period. Lastly, specific providers and settings were selected for the review if the provider self-assessment responses indicated non-compliance in three or more responses across the four domains of the survey or if the participant survey indicated differences from the provider responses in multiple areas. In total, 76 settings were selected for an onsite review, which represented all 40 in-state provider agencies. No out of state provider agencies were selected for the onsite review. As indicated in the Plan (pages 40), DDDS will accept the survey results for compliance with the HCBS final rule of the state in which these agencies are physically located.

The onsite review team used a standardized tool developed for the onsite reviews primarily based on the Council on Quality and Leadership (CQL) toolkit and customized for each type of waiver service. The tool included specific evaluation questions related to participant choice of a non-disability setting, setting location relevant to other institutional settings, findings from previous QSRs, the provider self-assessment, participant surveys, incident reports and interviews with staff/participants at the setting. The standardized tool included review areas that were exclusively focused on evaluating the isolation of individuals from the broader community. DDDS also required provider settings to submit policies, procedures and staff orientation materials in advance of the review and were included as part of the onsite review process.

DDDS completed the onsite reviews between February 2016 and May 2016. Provider agency staff that participated in the onsite review included executive directors, program coordinators, and house managers. DDDS also interviewed participants at the setting during the onsite review process when participants were available.

Onsite Review Findings and Remedial Actions

At the conclusion of the site-specific assessment process, DDDS was able to display the results for the provider settings in four categories:

- Category 1: Setting is compliant with federal HCB settings requirements.
- Category 2: Setting will be compliant with modifications.
- Category 3: Setting cannot meet federal HCB setting requirements and will be removed from the program.
- Category 4: Delaware will submit the setting for CMS heightened scrutiny review.

Based solely on the onsite review and not having a residency agreement in place, DDDS found that 56 provider settings selected for review were fully compliant with federal HCB settings requirements. Twenty provider settings were found to be compliant with modification and were required to submit a CAP. No provider settings surveyed as part of the onsite review will require removal from the program and/or the relocation of individuals (Category 3 – Delaware does not plan to submit any DDDS settings for heightened scrutiny review) (Category 4 – described below in *Heightened Scrutiny*).

The following table shows the complete results of the onsite review of a minimum 20% sample of DDDS HCBS provider settings.

Setting Type	Compliant	Compliant w/ Modification	Removed from Program	Heightened Scrutiny
Day Habilitation	3	4	0	0
Prevocational Service	4	0	0	0
Residential Habilitation*	48	15	0	0
Supported Employment	1	1	0	0
Total Settings (76)	56	20	0	0

**Neighborhood Group Home, Community Living Arrangement, Shared Living*

Following the completion of the onsite reviews, DDDS issued a "Notice of Findings" to each provider setting noting areas of non-compliance with federal HCB settings requirements. Provider settings were also given the opportunity to dispute any of the non-compliance findings and submit a request for reconsideration within 10 days from the date of the notice (see the Plan for details regarding the provider dispute resolution process page 39). No provider settings appealed the results of the onsite review.

Provider settings that were deemed "compliant" following the site-specific assessment process were notified by the DDDS of their compliance and required no remedial action. These provider settings will be subject to ongoing monitoring activities moving forward by DDDS, including annual QSRs.

Provider settings that were deemed "non-compliant with modification", were issued a "Notice of Findings" and were required to submit a CAP describing in detail the remediation activities (for each non-compliant finding) that will be implemented to ensure compliance and the associated timeframe to complete the activities. Provider settings were required to submit their CAP to DDDS within 60 days of receipt of the notice for each non-compliant finding. CAPs for all settings were submitted within the required timeframe and will be closely monitored by DDDS. To sufficiently address the CAP, providers are required to submit evidence to DDDS for each non-compliant finding noted in the "Report of Findings". The evidence required by the provider varies based on the type of non-compliant finding. For

example, a provider noted for not having locks on bedroom doors are required to submit a work order and other evidence to demonstrate compliance. Providers noted for not offering participant choice pertaining to their daily schedule, are required to submit revised policies and procedures and describe steps the provider will take to enable participants more autonomy with their daily schedules. DDDS will validate all evidence submitted for each non-compliant finding through future QSR reviews and annual site evaluations and will provide technical assistance as appropriate. DDDS has also developed a quality manual that details standards by service type to assist providers with implementing the federal HCB setting requirements in their CAP. DDDS requires that all provider settings are in compliance with federal HCB settings requirements by March 17, 2019.

The following table shows the final results of the site-specific provider assessment for all DDDS HCBS provider settings, including changes to the ratings made as a result of the onsite review.

Setting Type	Compliant	Compliant w/ Modification	Removed from Program	Heightened Scrutiny
Day Habilitation	5	29	1	0
Prevocational Service	6	2	0	0
Residential Habilitation*	0	429	1	0
Supported Employment	9	0	0	0
Total Settings 482	20	460	2	0

**Neighborhood Group Home, Community Living Arrangement, Shared Living*

In summary, 461 settings were evaluated through the site-specific assessment process. Seventy-six settings were selected to have a look behind completed by the OQI. There are 460 provider settings, including Shared Living that reported "compliant with modification" with the most commonly required modification being a residency agreement. Following the desk review, one additional setting was found to be out of compliance. One setting that had originally been reported as non-compliant was changed to compliant due to provider misinterpretation of the survey questions. The remaining 74 sites remained the same. Two provider settings will be removed from the program. No provider setting will be subject to heightened scrutiny.

Key Themes

The site-specific assessments revealed three common themes of non-compliance across provider settings. The first theme noted for residential and shared living settings related to the lack of participant protections under the Delaware landlord/tenant code, which have been addressed as part of the systemic assessment process detailed in Attachment 6 of the Plan. A second theme noted for residential and shared living settings, participants were not offered the opportunity to have a key or access device to the home or to appropriately lock bedroom doors. A third theme noted primarily for day programs, participants were unable to adequately choose their schedules to ensure choice of activities and integration with the community. In some cases, provider settings began to address non-compliant findings as a result of the desk review process prior to the onsite reviews and continue to address each finding through the CAP process. To remedy these issues, DDDS is in the process of issuing new service standards to help guide provider settings with compliance. DDDS has assigned OQI staff to support

provider settings with developing continuous quality improvement plans in this area and to provide technical assistance as needed.

Heightened Scrutiny

As a result of the site-specific assessment, DHSS identified one HCBS provider setting as warranting heightened scrutiny review. Gilpin Adult Daycare, an Adult Day Program located at 1101 Gilpin Avenue, Wilmington Delaware 19806, is located on the ground floor of a nursing home. Following this finding, DMMA contacted CMS for further guidance and will submit an evidentiary package for the setting. The evidentiary package for Gilpin Hall (as well as any HCB provider setting having institutional characteristics) will contain the documentation warranted sufficient to overcome the presumed institutional qualities, including but not limited to:

- Licensure requirements or other state regulations for the setting clearly distinguishing it from institutional licensure or regulations.
- Residential housing/zoning requirements showing that the location is integrated in and supports full access to the greater community.
- Provider qualifications/certifications for HCBS to prove staff at the facility is trained specifically for HCBS support consistent with the regulations.
- Service definitions that explicitly support the setting requirements.
- Procedures enacted by the setting indicating support for activities in the greater community according to the individual's preferences and interests.
- Documentation that individuals selected the setting from among setting options, including non-disability-specific settings.
- Description of proximity to avenues of available public transportation or explanation of other transportation opens where public transportation is limited.
- Pictures of the site and other demonstrable evidence.
- A report from an onsite visit to the setting conducted by the State.
- Member interviews outside the presence of the provider conducted by an independent entity of State staff with demonstrated expertise and/or training working with the relevant population.

The heightened scrutiny request will be submitted to CMS November 1, 2016.

Beneficiary Relocation

The following is a description of the beneficiary relocation process that will be implemented for all Delaware HCBS programs (i.e., DSHP, DDDS HCBS Waiver, PROMISE and Pathways).

Case managers will work with affected members to ensure continuity of care and transition to a new provider and to find alternative providers, taking into consideration the member's preferences, interests and needs. Case managers will educate members about the relocation process, timeframes and the member's rights. Case managers will support the member in making an informed choice of providers

from alternative providers that comply with the federal HCB settings requirements and will provide the necessary assistance to ensure this occurs.

MCOs or the operating agencies will send to the member and/or the member's caregiver or member's representative a formal notification letter no less than 30 calendar days prior to relocation that outlines the specific reason for the relocation and the relocation process and timeline. MCOs or operating agencies will also send the member's current provider a notification letter no less than 45 calendar days prior to relocation indicating the intent to relocate the member. The letter will direct the provider to participate with, as appropriate, DMMA, MCOs, operating agencies and other entities, in activities related to relocating the member.

Case managers will ensure that all services are in place in advance of the member's relocation and will monitor the transition to ensure successful placement and continuity of services. Case managers will conduct an onsite review of the member's new setting prior to the member's relocation and will touch base with members within the first 30 calendar days following transition, 90 calendar days after transition and ongoing as part of regularly scheduled visits to monitor the success of the transition.

Case managers will update the person-centered service plan as appropriate at all stages of the relocation process to note any identified issues and follow-up activities required with the member or the member's providers.

Ongoing Monitoring

Delaware will implement a comprehensive approach to ongoing monitoring. The approach will consist of obtaining feedback from multiple levels of the system, including but not limited to: the person-centered planning process, case manager touch points with members, provider credentialing/re-credentialing, provider enrollment and verification processes, and quality reviews. When issues are identified, as appropriate, DMMA, MCOs, DDDS or other operating agencies will work with providers individually to address non-compliance in a timely fashion. In addition, data will be collected and analyzed (on a provider setting level) in order to track and identify trends and root causes, and to make necessary systems, policy and/or operational changes in order to prevent reoccurrence. Also, DHSS will ensure that follow-up occurs in all instances when there is a complaint regarding a non-compliant provider setting.

The monitoring process will include ongoing strategies to address two important issues identified by CMS in its questions to the State: 1) the availability of non-disability specific providers, 2) preventing reverse integration and 3) assessment of privately owned settings.

Monitoring starts with the person-centered planning process, the foundation for assessing needs and developing a service plan that addresses identified needs. During this process, when members select their providers, they are given the names of both disability and non-disability specific providers to choose from. DHSS will regularly monitor its provider network to ensure that non-disability specific providers remain a viable option for members. This monitoring will occur through External Quality Review (EQR) as well as DMMA's Quality Review team.

Ongoing monitoring of the appropriateness of HCB settings will also include assessing to ensure that reverse integration does not occur. This will be assessed through case manager touch point meetings, onsite reviews and quality reviews.

Case manager onsite touch point meetings will be used as the primary source to identify if members are residing in privately owned settings that are institutional in nature. If identified, these providers will be held to the same processes noted below regarding identification and remediation of non-compliant issues.

The following sections present information on how ongoing monitoring processes, activities and timeframes will be implemented for DSHP, DDDS HCBS Waiver and the PROMISE and Pathways programs.

DSHP

During quarterly onsite touch point meetings, MCO case managers will assess members' experience and provider compliance with federal HCB settings requirements. Case managers will use a tool developed by DMMA that will build on the CMS exploratory questions. The tool is intended to assess at a minimum: members' community access, services, living space and interactions with provider staff.

If a case manager determines that a member may be receiving HCBS in a setting that is not compliant with the federal HCB settings requirements, the case manager will notify the appropriate MCO staff within 24 hours of identifying an issue. The MCO will ensure the setting is reviewed to determine if it is compliant with all applicable federal HCB settings requirements, using a tool provided to the MCOs from DMMA that builds on the CMS exploratory questions. In the event the MCO confirms the provider is not compliant:

- The MCO will report the non-compliant provider to DMMA in writing within 48 hours of confirmation of the compliance issue(s), using the Move IT file transfer system.
- The MCO will document the identified compliance issue(s) and notify the provider of the MCO's findings. The MCO will work with the provider to develop a CAP to address the compliance issue(s).
- The MCO will provide a full written report to DMMA within 10 business days of identifying the non-compliant provider including, at minimum, information regarding the identified issue(s), the MCO's findings, and any CAP(s) to remediate the issue(s).
- DMMA will review and approve all provider CAPs.

The MCO will monitor the provider's implementation of the CAP to ensure timely and appropriate action is taken. Upon completion of the CAP, the MCO will ensure the setting is reviewed to determine if it is compliant with all applicable federal HCB settings requirements. If the setting is determined compliant, the MCO will notify DMMA. The MCO will work with the provider to ensure that any non-compliant issue is completely remediated within 60 calendar days of identifying the issue.

In the event the issue cannot be resolved and the MCO determines the setting is not compliant with the federal HCB settings requirements, the case manager will work with the member to ensure continuity of

care and transition to a new provider as appropriate (see additional details in *Beneficiary Relocation* above).

New providers to the system (defined as providers not assessed as part of the initial Plan assessment activities) must meet all HCB settings requirements prior to providing services to HCBS members. As prescribed by DMMA, MCOs will incorporate HCB settings requirements and timeframes into their credentialing processes. MCOs will also incorporate HCB settings requirements into their annual HCBS provider re-credentialing process, to ensure that participating HCBS providers are assessed annually to ensure continued compliance with all applicable federal requirements. The MCOs will require that any providers determined non-compliant develop a CAP that specifies all relevant remediation activities and timeframes for completion. Providers ultimately found to be unable to meet HCB settings requirements will be disenrolled from the program. Affected members will be transitioned to a new provider following the beneficiary relocation process described in the *Beneficiary Relocation* section of this Amendment.

DDDS

DDDS will use a similar ongoing monitoring process and timelines as those noted above for DSHP. Details of DDDS' ongoing monitoring approach can be found in the Plan (pages 41-42). DDDS' ongoing monitoring strategy will differ from the process described above for DSHP in so far as DDDS will have primary responsibility for monitoring functions, as opposed to the MCOs for DSHP. DDDS will update DMMA on the status of identified issues (at the provider setting level), remediation activities and timeframes during the standing HCBS oversight quarterly meeting. This will be a standing agenda item.

The following list describes the key elements of DDDS' ongoing monitoring approach:

- The DDDS Authorized Provider Committee will be responsible for ensuring that all new waiver providers demonstrate compliance with the HCBS final rule during the credentialing process prior to enrollment.
- Hewlett Packard Enterprise, the State's current provider enrollment contractor, will be responsible for requiring evidence that each waiver provided has been credentialed by DDDS, including compliance with HCB settings requirements, as part of the provider enrollment process.
- Ongoing review of provider compliance will occur during the annual provider review conducted by the DDDS OQI. This means that, while the onsite review only included a sample of the DDDS provider settings, by May 2017, all settings will have had an onsite review to assess compliance with the HCBS final rule at annual provider validation, and will also be the responsibility of the State's provider enrollment contractor.
- DDDS OQI will be responsible for monitoring compliance with the DDDS standards, which will include the HCBS requirements no later than July 2018, via two structured processes: a QSR which is performed for a sample of members and an annual site visit for all providers providing residential or day services.
- DDDS will ensure that provider issues are identified timely. DDDS will develop tools for case managers to assess provider compliance issues during touch point meetings.

- When issues are identified, DDDS will require provider CAPs that will be subject to DDDS approval. DDDS will ensure that identified issues are addressed timely through the CAP process.

Pathways and PROMISE

The applicable operating agencies, Delaware's Division of Substance Abuse and Mental Health (DSAMH) for PROMISE and DDDS/Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) for Pathways, will be responsible for the ongoing monitoring activities described above and will provide updates to DMMA. The operating agencies will update DMMA on the status of identified issues (at the provider setting level), remediation activities and timeframes at the monthly Pathways status meetings.

Milestones

The following chart notes the comprehensive milestones (tasks and associated timeframes) to be accomplished by DHSS to review and assess the Delaware HCBS system of care and demonstrate full compliance with all HCB settings requirements.

Milestone	Description	Proposed End Date	STP Page No.
Systemic Assessment and Remediation			
Completion of systemic assessment review *July 11, 2016*	DSHP Demonstration: Evaluate any current DMMA required training, including materials and curriculum, against the HCBS final rule.	3/31/2015 Completed	22-25, 54-57, Attachment 6
	DSHP Demonstration: Use survey tool to assess State policies, procedures, etc. against the HCBS final rule to determine whether policies, etc. are compliant with the final rule or whether there are gaps. Develop inventory of results.	9/17/2015 Completed	
	DSHP Demonstration: Conduct systemic assessment – evaluate laws, policies, standards, etc. against HCBS final rule.	9/30/2015 Completed	
	DSHP Demonstration: Evaluate current service definitions against the requirements of the HCBS final rule.	9/30/2015 Completed	
	DSHP Demonstration: Evaluate current MCO required training, including materials and curriculum against the HCBS final rule.	12/1/2015 Completed	
	DDDS Waiver: Use survey tool to assess for DDDS policies, procedures, etc. against the HCBS final rule to determine whether DDDS policies, etc. are compliant with the final rule or whether there are gaps.	9/17/2015 Completed	
	DDDS Waiver: Evaluate current waiver service definitions against the new requirements.	10/15/2015 Completed	
	DDDS Waiver: Identify internal policies that are not compliant and require remediation.	3/31/2016 Completed	
	DDDS Waiver: Identify state laws and regulations that re not compliant and require remediation.	3/31/2016 Completed	
	DDDS Waiver: Analyze DDDS waiver provider qualification standards and internal procedures to determine compliance with the HCBS final rule or whether there are gaps.	3/31/2016 Completed	
	DDDS Waiver: Evaluate current DDDS required training against	Completed	

Milestone	Description	Proposed End Date	STP Page No.
	the HCBS final rule.		
	DDDS Waiver: Determine if the College of Direct Support curriculum has been vetted against the HCBS final rule.	Completed	
	DSHP Demonstration and DDDS Waiver: Conduct review of Delaware landlord/tenant code vis-à-vis the final rule.	DSHP: 4/3/2015 Completed DDDS: 4/30/15 Completed	
Complete modifying rules, regulations and standards, including provider manuals, inspection manuals, procedures, laws, qualification criteria, etc. Implementation of new rules, regulations and standards: 50% complete *July 1, 2017* Implementation of new rules, regulations and standards: 100% complete *July 1, 2018*	DSHP Demonstration: Create explanation in plain language of tenant rights to be given to all HCBS members that reside in provider-owned or leased properties.	6/30/2015 Completed	24-25, 28-29, 56-57, 60-61, Attachment 6
	DSHP Demonstration: Make any necessary changes to training materials and/or curriculum to ensure compliance.	6/30/2015 Completed	
	DSHP Demonstration: Providers make any changes to any non-compliant policies, procedures, laws, regulations, etc. Changes must be approved by DMMA.	Ongoing Start date: 6/2/2016	
	DSHP Demonstration: Develop remediation strategies for any State laws, regulations, policies, etc. that are found not fully compliant.	7/31/2016 Completed	
	DSHP Demonstration: MCOs make any necessary changes to any noncompliant policies (must be reviewed and approved by DMMA).	11/30/2016	
	DSHP Demonstration: Make any necessary changes to MCO contracts.	11/30/2016	
	DSHP Demonstration: Make any necessary changes to State policies, procedures, laws, regulations, etc.	1/31/2017	
	DSHP Demonstration: MCOs make any necessary changes to required trainings (including materials and/or curriculum) to ensure compliance. DMMA must approve changes.	Ongoing Start date: 4/1/2015	
	DSHP Demonstration: MCOs implement new curriculum and evaluate effectiveness, as appropriate.	Ongoing Start date: 7/1/2015	
	DSHP Demonstration: Implement new MCO contract requirements, as appropriate.	Ongoing Start date: 11/30/2016	

Milestone	Description	Proposed End Date	STP Page No.
	DDDS Waiver: Create explanation in plain language of tenant rights to be given to all waiver members that reside in provider-owned or leased properties.	6/30/2015 Completed	
	DDDS Waiver: Change DDDS policy regarding training curriculum. Add or delete CDS modules that will facilitate staff and provider compliance with the HCBS final rule. Work with Elsevier to add new modules as necessary.	9/30/2015 Completed	
	DDDS Waiver: Implement new [training] curriculum as necessary.	12/31/2015 Completed	
	DDDS Waiver: Develop a Continuous Quality Improvement Curriculum for providers.	9/30/2016	
	DDDS Waiver: Make necessary changes to Division policies, procedures, laws, regulations, etc.	10/31/2016	
	DDDS Waiver: Make necessary changes to DDDS Provider qualification criteria, form and practices.	10/31/2016	
	DDDS Waiver: Develop a policy regarding aging in place.	11/1/2016	
	DDDS Waiver: Make necessary changes to state or DHSS policies, procedures, laws, regulations, etc.	1/31/2017	
	DDDS Waiver: Make necessary changes to DDDS waiver provider standards to codify expectations via the HCBS final rule.	7/1/2018	
	DDDS Waiver: Implement new provider standards.	7/1/2018	
	DDDS Waiver: Implement changes to DDDS waiver provider standards to codify expectations via the HCBS final rule.	7/1/2018	
	DDDS Waiver: Submit necessary changes to the DDDS HCBS waiver application to CMS to communicate and enforce expectations re: the final rule.	6 months after CMS approval	
	DDDS Waiver: Add QA measures in the waiver application specific to the HCBS final rule.	Within 9 months of CMS approval of the Plan	

Milestone	Description	Proposed End Date	STP Page No.
Site-specific Assessment			
Completion of site-specific assessment *February 28, 2017*	DSHP Demonstration: Develop survey instruments for providers to self-assess their policies, procedures, etc. against the HCBS final rule. Develop tool to assess State laws, regulations, codes, policies, etc. for compliance with the final rule. Work with DSHP MCOs to develop tool for MCOs to review compliance of their policies and procedures with the final rule.	7/31/2015 Completed	22, 25-28, 55-59 Amendment 1: 3-5, 6-9
	DSHP Demonstration: Develop a provider self-assessment tool for residential and nonresidential providers/sites.	7/31/2015 Completed	
	DSHP Demonstration: Conduct a pilot with selected providers to work out the bugs of the survey instrument.	7/21/2015 Completed	
	DSHP Demonstration: Analyze results of pilot and make corrections to the survey instrument and develop a training curriculum.	7/31/2015 Completed	
	DSHP Demonstration: Develop a participant survey tool.	7/31/2015 Completed	
	DSHP Demonstration: MCOs review their policies and internal procedures to determine compliance with the HCBS final rule; As part of the self-assessment response, MCOs will be required to submit a corrective action plan for any policies or procedures deemed not to be fully compliant.	10/31/2015 Completed	
	DSHP Demonstration: Implementation of assessment: Residential and non-residential providers take the self-assessment, and MCO case managers assist participants with the participant survey.	1/1/2016 Completed	
	DSHP Demonstration: Collect, analyze and evaluate provider self-assessment and participant survey responses and develop report.	1/15/2016 Completed	
	DSHP Demonstration: Conduct review of MCO self-assessment results re: their policies and procedures and remediation strategies.	1/31/2016 Completed	
	DSHP Demonstration: Desk review of provider self-assessment results re: their policies and procedures and remediation strategies.	3/1/2016 Completed	
	DSHP Demonstration: Conduct onsite look-behind reviews of all	3/31/2016	

Milestone	Description	Proposed End Date	STP Page No.
	providers.	Completed	
	DSHP Demonstration: Issue report of findings to providers following onsite review.	6/2/2016 Completed	
	DSHP Demonstration: As necessary, develop a demonstration amendment to revise any service definitions and submit amendment to CMS. Work with CMS toward approval of the amendment.	Start date: Within 9 months of CMS approval of the Plan	
	DDDS Waiver: Develop survey instrument to use to assess for DDDS and provider (self-assessment) policies, procedures, etc. against the HCBS final rule.	7/31/2015 Completed	
	DDDS Waiver: Develop a provider self-assessment tool for residential and nonresidential providers/sites.	8/7/2015 Completed	
	DDDS Waiver: Conduct a pilot with one residential and day program to work out the bugs of the survey instrument.	8/7/2015 Completed	
	DDDS Waiver: Analyze results of pilot, make corrections to the survey questions, add the questions to Survey Monkey and develop a set of instructions for the providers.	9/4/2015 Completed	
	DDDS Waiver: Present provider self-assessment survey tool to providers and instructions for its use.	9/10/2015 Completed	
	DDDS Waiver: State desk reviews of provider self-assessments.	1/31/2016 Completed	
	DDDS Waiver: Implement a participant survey.	2/20/2016 Completed	
	DDDS Waiver: Communicate with authorities in other states outside of Delaware in which Delaware waiver members reside to assess compliance based on that state's assessment.	3/31/2016 Completed	
	DDDS Waiver: Issue report of findings to providers following the provider self-assessment and desk audit.	3/31/2016 Completed	
	DDDS Waiver: Conduct onsite “look-behind” review of a 20% sample of providers using the review tool.	5/31/2016 Completed	
	DDDS Waiver: Issue report of findings to providers following onsite review.	5/31/2016 Completed	

Milestone	Description	Proposed End Date	STP Page No.
	DDDS Waiver: Public input will be sought for regulatory changes via the Delaware Register of Regulations.	1/31/17	
	DDDS Waiver: Complete participate survey.	2/28/2017	
	DDDS Waiver: Conduct a full review of provider settings for all providers not reviewed as part of the compliance above at the next provider QA review.	Start date: First review date after 7/1/16 End date: Ongoing on provider review annual anniversary date	
	DSHP Demonstration and DDDS Waiver: Develop process for providers to dispute findings.	DSHP: 3/31/2016 Completed DDDS: 2/26/2016 Completed	
Updated Final STP			
Submit final STP to CMS November 21, 2016	DSHP Demonstration and DDDS Waiver: Update STP to include the following and submit for public comment. • Address CMS outstanding concerns • Incorporate results of assessments • Include heightened scrutiny request	10/1/2016	
	DSHP Demonstration and DDDS Waiver: Public hearings.	10/24/2016 and 10/25/2016	
	DSHP Demonstration and DDDS Waiver: Submit updated STP to CMS for final approval.	11/21/2016	
Site-specific Remediation[1]			
Completion of residential provider remediation: 25% *December 30, 2016* Completion of residential provider remediation: 50% *June 30, 2017*	DSHP Demonstration: DMMA sends CAP request to MCOs.	2/8/2016 Completed	28, 59-60 Amendment 1: 5-6, 9-11
	DSHP Demonstration: MCO CAPs due to DMMA (30 days following receipt of DMMA notice).	3/11/2016 Completed	
	DSHP Demonstration: DMMA responds to MCO CAPs.	3/31/2016 Completed	
	DSHP Demonstration: DMMA sends CAP requests to providers.	6/2/2016	

Milestone	Description	Proposed End Date	STP Page No.
Completion of residential provider remediation: 75% *December 30, 2017* Completion of residential provider remediation: 100% *July 1, 2018* Completion of nonresidential provider remediation: 25% *December 30, 2016* Completion of nonresidential provider remediation: 50% *June 30, 2017* Completion of nonresidential provider remediation: 75% *December 30, 2017* Completion of nonresidential provider remediation: 100% *July 1, 2018*		Completed	
	DSHP Demonstration: Providers submit CAP to DMMA (30 days following receipt of DMMA notice).	7/5/2016 Completed	
	DSHP Demonstration: Review and approval of provider CAPs.	Ongoing	
	DDDS Waiver: Implement process for providers to dispute findings.	2/26/2016 Completed	
	DDDS Waiver: Providers submit CAP to DDDS following desk review.	4/1/2016 Completed	
	DDDS Waiver: Providers submit CAP to DDDS following onsite review.	8/15/2016 Completed	
	DDDS Waiver: Review and approval of provider CAPs.	9/1/2016 Completed	
	DDDS Waiver: Relocate individuals in residential provider settings found to be institutional in nature.	3/30/2017	
	DDDS Waiver: New model agreements for residential provider settings.	12/30/2017	
	DSHP Demonstration and DDDS Waiver: Completion of all MCO and Provider CAPs	7/31/2018	
	DSHP Demonstration and DDDS Waiver: Completion of identification of settings that will not remain in the HCBS System.	7/31/2018	
Heightened Scrutiny[2]			
Identification of settings that overcome the	DSHP Demonstration: Identify residential sites covered under HCBS that are PRESUMED NOT to be community based (e.g.,	4/30/2015 Completed	25-26, 57-58 Amendment 1: 12

Milestone	Description	Proposed End Date	STP Page No.
presumption and will be submitted for heightened scrutiny and notification to provider	Stockley).		
	DDDS Waiver: Identify residential sites covered under the waiver that are PRESUMED NOT to comply with the HCBS final rule because they are not on the grounds of a public institution.	4/30/2015 Completed	
	DSHP Demonstration and DDDS Waiver: Incorporate list of settings requiring heightened scrutiny and information and evidence referenced above into the final version of STP and release for public comment.	9/15/2016 Completed	
	DSHP Demonstration and DDDS Waiver: Identify residential sites (including out of state) paid for with a) waiver funds or b) DSHP/demonstration funds that are likely to NOT be community based.	9/30/2015 Completed	
	DSHP Demonstration and DDDS Waiver: Complete gathering information and evidence on settings requiring heightened scrutiny that will be presented to CMS.	10/28/2016	
	DSHP Demonstration and DDDS Waiver: Submit heightened scrutiny request to CMS (as part of updated Plan)	11/21/2016	

Milestone	Description	Proposed End Date	STP Page No.
Relocation			
Complete notification of members and all parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 25% *July 28, 2017* Complete notification of members and all parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 50% *December 29, 2017* Complete notification of members and all responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required: 75% *May 31, 2018* Complete notification of members and all parties that the setting is not in compliance with HCBS settings requirements and	DSHP Demonstration and DDDS Waiver: Transition Remaining two waiver members off the Stockley ICF-IID grounds. A new home is being built to meet their specific needs.	3/30/2017	59, Amendment 1: 12-13

Milestone	Description	Proposed End Date	STP Page No.
that relocation is required: 100% *August 10, 2018* Complete beneficiary relocation across all providers: 25% *January 31, 2018* Complete beneficiary relocation across all providers: 50% *May 31, 2018* Complete beneficiary relocation across all providers: 75% *September 30, 2018* Complete beneficiary relocation across all providers: 100% *December 28, 2018*	DSHP Demonstration and DDDS Waiver: Completion date of notifying member, guardians, case managers, facility support staff and any other identified responsible parties that the setting is not in compliance with HCBS settings requirements and that relocation is required. (The trigger to complete the process is the 7/31/2018 completion date of identification of settings that will not remain in the system. However, notification will occur as soon as settings are identified, which will be an ongoing process.)	8/10/2018	
	DSHP Demonstration and DDDS Waiver: Beneficiary relocation process completed.	12/28/2018	

[1]This section includes only those providers where remediation was required.

[2]The first 3 Heightened Scrutiny milestones should be completed prior to resubmitting the STP to CMS (the fourth HS milestone).

Quarterly reporting: After the initial and final approval of the STP, CMS may request quarterly updates on the STP implementation progress. The following milestones will provide a system to monitor the submission of these reports. NOTE: This section will be completed by CMS following approval of the Plan.

Milestone	Description	Proposed End Date
Quarterly progress update *[First quarter after initial and final approval.]*		
Quarterly progress update *[Second quarter after initial and final approval.]*		
Quarterly progress update *[Third quarter after initial and final approval.]*		
Quarterly progress update *[Fourth quarter after initial and final approval.]*		
Quarterly progress update *[Fifth quarter after initial and final approval.]*		
Quarterly progress update *[Sixth quarter after initial and final approval.]*		
Quarterly progress update *[Seventh quarter after initial and final approval.]*		

Please use the following section to provide any additional milestones for which the State would like to provide information to CMS. These milestones are optional; any listed milestones will be tracked in the CMS website and should reflect any major progress. More incremental progress does not have to be noted.

Milestone	Description	Proposed End Date	STP Page No.
Additional			
Rate Development			
	DDDS Waiver: Review DDDS rates for adequacy to support the requirements of the HCBS final rule (especially related to smaller staffing ratios in the day programs).	12/30/2016	60
	DSHP Demonstration: Review rates for adequacy to support the requirements of the HCBS final rule (especially related to smaller staffing ratios in the day programs).	9/30/2016	
	DSHP Demonstration: As appropriate, include a budget strategy related to any necessary changes to [staffing] rates [and any changes related] to any necessary changes to rates, especially related to smaller staffing ratios in the day programs.	No date	
Waiver Amendments and Related Activities			
	DDDS Waiver: As appropriate, develop a waiver amendment to revise any service definitions as necessary. Any waiver amendment will be submitted to CMS by DMMA.	No date; start date: Within 9 months of CMS approval of the Plan	25
	DDDS Waiver & DSPH Demonstration: As appropriate, revise the DMAP Provider manual for changes to waiver service definitions as necessary.	No date; start date: After approval of amendment by CMS	